STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
PoC #2	445292	A. BUILDING _____ B. WING _____	12/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEECH TREE MANOR	240 HOSPITAL LANE, PO BOX 300 JELLICO, TN 37762

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

During the annual Recertification survey and investigation of complaint number 35018, conducted on December 8-10, 2014, at Beech Tree Manor, no deficiencies were cited in relation to the complaint under 42 CFR PART 483.13, Requirements for Long Term Care.

F 315 SS=D 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER

F 315 F-315 Jan. 24, 2015

Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

This REQUIREMENT is not met as evidenced by:
Based on medical record review, observation, and interview, the facility failed to clearly indicate the size of the indwelling catheter for one resident (#56) of three residents reviewed for indwelling catheter use.

The findings included:

Resident #56 was admitted to the facility on September 9, 2009, with diagnoses including Kidney Stones, Neurogenic Bladder, Alzheimer's, Dementia with Behaviors, and Altered Mental Status.

F-315

(1) Physician orders for resident number 56 have been updated to indicate the catheter size should be an 18 Fr. This was completed on Tuesday, December 9, 2014. Maintenance of the indwelling catheter will remain as indicated in resident number 56 care plan.

(2) On Tuesday, December 9, 2014, a 100% audit was completed for all current residents with indwelling catheters. All physician orders were updated to include the size of catheter to be used for each of those residents. These orders have been included in the Electronic Health Record Batch Orders for current residents as well as any new admission.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
E. Darlene Herald	Administrator	12/24/14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEC 05 2015

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	445292	A. BUILDING _____ B. WING _____	12/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 1	F 315	(3) Physician orders determining the size of catheter to be used for each individual resident have been included in the Electronic Health Record Batch Orders for current residents as well as any new admission. Director of Nursing conducted impromptu in-servicing on December 9, 2014 for the licensed staff in the building for that day to remind them of the need to document the size of any indwelling catheter that may be ordered by attending physicians. All resident charts with indwelling catheters were reviewed and the size of catheter was updated for each. On December 18, 2014 an all-inclusive in-service was conducted by DON for all licensed staff to make them aware of deficiencies and corrective plan.	

Observation on December 8, 2014, at 8:40 a.m., revealed the resident in bed, with a catheter drainage bag inside a privacy bag, attached to the lower frame of the bed.

Observation on December 10, 2014, at 12:05 p.m., in the resident's room, revealed the resident received pericare. Continued observation revealed the catheter size was not visible.

Medical record review of the history and physical dated October 18, 2013, revealed, "...The patient developed bilateral renal stones recently. These large staghorn calculus...has been seen [by] a urologist at...for this. Both...[physicians] suggested conservative management of indwelling catheter because...[resident] is unable to tolerate any surgery for those stones according to urologist... "

Medical record review of the care plan interventions dated October 13, 2014, revealed, "I need foley cath care q [every] shift as and as needed; I need my foley cath changed q month and as needed. I need my foley cath irrigated as ordered and if I am incontinent I need good pericare provided..." Continued review revealed the catheter size had not been documented.

Interview with Licensed Practical Nurse #7 on December 9, 2014, at 1:35 p.m., at the 200 hall nurse's station, confirmed documentation of the catheter size had not been recorded in the electronic medical record or the chart documentation for resident #56.

Interview with the Director of Nursing on December 9, 2014, at 2:55 p.m., in the conference room, confirmed residents with

Please see attached page for #4 of F-315.

(Continued from bottom of page 2 of 11)

F-315

(4) The Director of Nursing or her designee will conduct audits of all catheter usage to assure that the medical record correctly reflects the size of catheter to be used for any resident in need of catheter insertion. These audits will be completed each month and reported to the Quality Assurance Committee at their quarterly meetings. The members of the QA committee are Medical Director, Administrator, Director of Nursing, Wound Care RN, Social Services, Activity Director, Food Service Director, Environmental Services, Maintenance Director, Medical Records, MDS Coordinators, Rehab Director, HR/Payroll, Billing, Infection Preventionist, Director of Purchasing and Procurement, and the Consulting Pharmacist.

Projected date of completion:
January 24, 2015.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445292	A. BUILDING _____ B. WING _____	12/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 315	Continued From page 2 indwelling catheters should have a physician order that specifies maintenance including the size of the catheter.	F 315		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, review of narcotic records, facility policy review, and interview, the facility failed to ensure the reconciliation of controlled medications for one medication of six medications reviewed for controlled substance reconciliation. The findings included:	F 425	F-425 (1) No residents are or were affected by the oversight to add a controlled medication to the narcotic tracking log at the time it was signed into the facility. This medication was provided by the Amedisys Hospice Contract Agency and had not been used since entering the facility and being placed in a locked box in a locked refrigerator inside the locked medication room. (2) During the evening shift of December 10, 2014, Director of Nursing completed a 100% audit of all Hospice residents and none of the other residents had any narcotic medication not tracked appropriately. (3) Director of Nursing held impromptu in-services on December 10, 2014 with her licensed nurses that were present on that day. She reminded them of the importance of not only signing	Jan. 24, 2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 425 Continued From page 3

Observation, during medication storage review, with Registered Nurse #1, revealed a 30 milliliter unopened bottle of Morphine Sulfate Solution (narcotic) (20 milligrams/2 milliliters) stored in the refrigerator in the 200 hall medication room.

Review of the facility's narcotic medication tracking log for the 200 hall revealed no documentation the facility had been reconciling the medication through daily controlled substance reconciliation to ensure the accuracy of medication administration.

Review of the Pharmacy's record for delivery and receipt revealed the facility had accepted delivery of the Morphine Sulfate Solution on October 31, 2014.

Review of the facility policy, Controlled Substances, revealed, "...Controlled substances must be counted upon delivery...if the count is correct, an individual resident controlled substance record must be made for each resident who will be receiving a controlled substance..."

Interview with the Director of Nursing on December 10, 2014, at 11:50 a.m., in the medication room, confirmed the facility had failed to initiate an individual resident controlled substance tracking sheet for the medication.

F 431 SS=E 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS

The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all

F 425

into the facility records any narcotics provided by Hospice but to immediately include them on the Narcotic Tracking Record. On December 18, 2014, another in-service was conducted by the Director of Nursing, including all licensed staff, that included not only those areas indicated in our statement of deficiency but other nursing expectations she has for exemplary resident care for all our residents.

(4) The Director of Nursing or her designee will audit all Hospice medications to assure any narcotic provided by Hospice rather than the facility pharmacy is not only signed into the facility upon arrival but also included in the Narcotic record of the individual patient and tracked correctly. Weekly, on Thursday, audits will be conducted for all medicines brought into the facility by Hospice to assure proper tracking.

F 431

F-431 (1) No residents are or were affected by the one refrigerator temperature in the locked medication room

Projected date of completion: January 24, 2015.

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	445292	A. BUILDING _____ B. WING _____	12/10/2014

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F 431	Continued From page 4 controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, review of manufacturer's recommendations for medication storage, and interview, the facility failed to maintain refrigerated medication storage per manufacturer's recommendations for one refrigerator (300 hall) of two refrigerators	F 431	on 300 hall being below that of the manufacturer's specifications for certain medications. (2) All medications were moved to another secure refrigerator on the evening shift of December 10, 2014. The refrigerator temperatures for this one refrigerator was monitored for the next few days to determine the fluctuations in temperature, there were fluctuations so the refrigerator has been replaced with a new one and temperatures are within the range of 36 to 46 degrees Fahrenheit. (3) The facility has a monitoring log in which temperatures are checked and documented on a daily basis. Any fluctuations in temperature are reported to the Director of Purchasing and a new thermometer is placed to double check the readings. If readings fluctuate for the next day or so, refrigerators are replaced with new equipment. The monitoring log has been updated to show action taken immediately when temperatures are outside the parameters of 36	

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F 431	Continued From page 5 observed. The findings included: Observation with Licensed Practical Nurse (LPN) #3 on December 10, 2014, at 10:50 a.m., in the 300 hall medication room, revealed the thermometer inside the refrigerator used for storing medications registered 22 degrees Fahrenheit (F). Continued observation revealed no visible signs of ice or frozen medications were in the refrigerator. Observation with LPN #2 on December 10, 2014, at 2:00 p.m., revealed the refrigerator temperature (utilizing a new thermometer approximately 2 hours after the first observation) revealed the refrigerator temperature registered 18 degrees F. Continued observation with LPN #2 revealed the contents of the refrigerator included two Pneumovax 5 milliliter (ml) vials, with manufacturer's instructions to store between 36-46 degrees F; two Influenza Vaccine 5 ml vials, with manufacturer's instructions to store between 36-46 degrees F; three Tuberculin Purified Protein vials with manufacturer's instructions to store between 35-46 degrees; and ten Pneumovax SDV (single dose vials) 25 mcg (micrograms)/0.5 ml with manufacturer's instructions to store between 36-46 degrees F. Interview with LPN #2 on December 10, 2014, at 1:50 p.m., in the 300 hall medication room, confirmed the medications had not been stored at the proper temperature.	F 431	to 46 degrees Fahrenheit. On December 18, 2014 an all-inclusive in-service conducted by the Director of Nursing informed all licensed staff of updates to the refrigerator logs and reporting any action taken if outside acceptable parameters. (4) Director of Nursing or her designee will audit the refrigerator temperature logs on a weekly basis times three months to assure temperatures are appropriate. Projected Date of Completion: January 24, 2014.	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441	F-441 (1) No residents are or were affected by the oversight of	Jan 24, 2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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BEECH TREE MANOR	240 HOSPITAL LANE, PO BOX 300 JELLICO, TN 37762

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F 441	Continued From page 6 The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by:	F 441	the restorative nursing assistant to use proper hand-washing techniques between each resident she served or provided assistance in the dining room. (2) Residents would have the potential for being affected when facility personnel are not following proper facility protocol when serving resident food or assisting residents with eating. Impromptu in-services were conducted by the Director of Nursing on December 10, 2014 for those staff in the building on this date to remind staff to use their pocket-size hand sanitizers or the sanitizers conveniently located at the entry/exit of each resident room as well as in each of the area where food is served when assisting residents with any care need. Director of Nursing conducted nursing unit in=services each shift until all certified nursing staff were re-educated about proper hand hygiene when serving food or assisting residents with eating. On December 18, 2014, Director of Nursing educated all licensed staff in her all-inclusive in-service.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445252	A. BUILDING _____ B. WING _____	12/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEECH TREE MANOR	840 HOSPITAL LANE PO BOX 369 JELLICO, TN 37762

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F 441	Continued From page 7 Based on observation, facility policy review, and interview, the facility failed to ensure staff performed hand hygiene to prevent cross contamination between residents in the dining room for eight of thirty-one residents observed receiving trays during meal service. The findings included: Observation on December 8, 2014, at 12:35 p.m., in the main dining room, revealed Certified Nurse Aide (CNA) #3 assisted a resident with transferring from a merriwalker to a dining room chair, placing both hands on the resident. Continued observation revealed CNA #3 moved another resident seated in a wheelchair closer to the table by touching the wheelchair bare-handed. Continued observation revealed without disinfecting the hands after touching two of the residents in the dining room, CNA #3 prepared a beverage, and served the beverage to another resident. Observation on December 8, 2014, at 12:40 p.m., revealed Certified Nurse Aide (CNA) #3 touched the resident seated at the third table, fourth row, and proceeded to prepare and serve beverages to five residents seated in the dining room without disinfecting the hands after touching the first resident. Observation on December 8, 2014, at 12:49 p.m., revealed CNA #3 touched his/her face with a bare hand, and proceeded to prepare and serve a beverage to a resident. Observation on December 8, 2014, at 1:06 p.m., revealed CNA #3 touched a resident's hands with bare hands and proceeded to serve a meal tray	F 441	(3) Audits will be conducted by the RN Infection Preventionist at a rate of 15 staff per week times three months. Following this initial three month period RN will conduct spot checks once per month per designated staff members chosen by her. (4) The results of the QA audits will be reported to the QA Committee and any variances will be corrected immediately. The members of the QA committee are Medical Director, Administrator, Director of Nursing, Wound Care RN, Social Services, Activity Director, Food Service Director, Environmental Services, Maintenance Director, Medical Records, MDS Coordinators, Rehab Director, HR/Payroll, Billing, Infection Preventionist, Director of Purchasing and Procurement, and Consulting Pharmacist. Projected date of completion: January 24, 2014	

F 441 Continued From page 8

to another resident seated in the second row, at the second table, without disinfecting the hands.

Review of the facility policy, Handwashing/Hand Hygiene, revealed, "...Employees must wash their hands for at least fifteen seconds using antimicrobial or non-antimicrobial soap and water under the following conditions...before and after direct resident contact...before and after assisting a resident with meals..."

Interview with CNA #3 on December 8, 2014, 1:45 p.m., in the dining room, confirmed the hands had not been disinfected after touching residents and resident equipment per the facility policy, and before preparing beverages and setting up meals for the residents.

F 514 SS=D 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE

The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.

The clinical record must contain sufficient information to identify the resident, a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced by:
Based on medical record review and interview,

F-514

(1) No residents are or were affected by the oversight of one resident's record containing a second resident's report.

(2) Medical Records Technician completed a 100% audit of all current residents hard chart. This audit was presented to the Director of Nursing who then completed a random sampling audit of both 200 and 300 hall residents, and found that all charts are correct for each resident indicated.

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F 514	Continued From page 9 the facility failed to ensure radiology and laboratory reports were placed on the correct medical record for one resident (#128) of twenty-nine residents reviewed. The findings included: Resident #128 was admitted to the facility on November 18, 2014, with diagnoses including Muscle Weakness, Scoliosis, Gout, Dementia without Behaviors, Hypertension, and a Closed Fracture to the Femur. Medical record review of the admission Minimum Data Set (MDS) dated November 25, 2014. revealed the resident scored a three on the Brief Interview for Mental Status (BIMS), indicating the resident was severely cognitively impaired, and required extensive assistance with activities of daily living Medical record review on December 9, 2014, at 2:30 p.m., revealed the laboratory values and radiology imaging studies for resident #13 were on resident #128's medical record. Medical record review revealed the radiology imaging studies for resident #13 revealed "...CT [computed tomography - a radiology test] Abdomen Pelvis w/o [without] contrast...impression...small bowel obstruction is noted..." Further medical record review revealed the laboratory values for resident #13 were within normal values. Further medical record review revealed resident #128 had no history of a small bowel obstruction. Interview with Licensed Practical Nurse (LPN) #2 on December 9, 2014, at 2:50 p.m., in the	F 514	(3) Monthly audits will be completed by the Medical Records Clerk of an equal number of resident's medical hard chart with 100% of the charts being audited on a quarterly basis. If there were to be any discrepancies in the charts, same will be documented on the audit reports, corrected and documented as such, then reports will be provided to the Director of Nursing for any additional follow-up. Director of Nursing held an all-inclusive in-service for licensed personnel on December 18, 2014 reminding all nurses to review/audit charts routinely to assure correct information is being utilized for the care of individual residents/patients. (4) Administrator and Director of Nursing will conduct sample audits on a weekly basis to assure adherence to correct information being placed in each individual resident/patient chart. Projected date of completion: January 24, 2014.	

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F 514	Continued From page 10 Secured Unit Nurse's Station, confirmed the radiology and laboratory reports for resident #13 were incorrectly placed on resident #128's medical record. Interview with the Director of Nursing (DON) on December 9, 2014, at 3:07 p.m., in the DON office, confirmed the radiology and laboratory reports for resident #13 were incorrectly placed on resident #128's medical record and the medical record was inaccurate.	F 514		